IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CEDAR RAPIDS DIVISION

THOMAS J. ANDERSON, Plaintiff, vs. MICHAEL J. ASTRUE, Commissioner of Social Security, Defendant.	No. C06-0187 **RULING ON JUDICIAL REVIEW**

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I. INTRODUCTION

This matter comes before the Court on the Complaint (docket number 1) filed by Plaintiff Thomas J. Anderson on December 31, 2006, requesting judicial review of the Social Security Commissioner's decision to deny his application for Title II disability insurance benefits. Anderson asks the Court to reverse the decision of the Social Security Commissioner ("Commissioner") and order the Commissioner to provide him disability insurance benefits. In the alternative, Anderson requests the Court to remand this matter for further proceedings.

II. PRIOR PROCEEDINGS

Anderson applied for disability insurance benefits on September 19, 2003.[1] In his application, Anderson alleged an inability to work since July 11, 2003 due to deep vein thrombosis, fibromyalgia, chronic fatigue syndrome, and rheumatoid arthritis. Anderson's application was denied on October 29, 2003. On January 22, 2004, his application was denied on reconsideration. On February 10, 2004, Anderson requested an administrative hearing before an Administrative Law Judge ("ALJ"). On October 6, 2005, Anderson appeared with counsel before ALJ Jean M. Ingrassia for an evidentiary hearing. Anderson, Anderson's wife, Dianna Anderson, and vocational expert Carma Mitchell testified at the hearing. In a decision dated January 11, 2006, the ALJ denied Anderson's claim. The ALJ determined that Anderson was not disabled and was not entitled to disability insurance benefits because he was functionally capable of performing his past relevant work as a book store attendant and had transferable skills to perform work that exists in significant numbers in the national economy. Anderson appealed the ALJ's decision. On November 2, 2006, the Appeals Council denied Anderson's request for review. Consequently, the ALJ's January 11, 2006 decision was adopted as the Commissioner's final decision.

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[1] Prior to September 19, 2003, Anderson applied for disability insurance benefits on July 17, 2000; however, Anderson withdrew this application in writing on September 4, 2000. *See* Administrative Record at 63-66.

On December 31, 2006, Anderson filed this action for judicial review. The Commissioner filed an answer on May 4, 2007. On July 26, 2007, Anderson filed a brief arguing there is not substantial evidence in the record to support the ALJ's finding that he is not disabled and that he can perform his past relevant work as a book store attendant or that there is other work he can perform. On September 26, 2007, the Commissioner filed a responsive brief arguing the ALJ's decision was correct and asking the Court to affirm the ALJ's decision. Anderson filed a reply brief on October 2, 2007. On April 20, 2007, both parties consented to proceed before the undersigned in this matter pursuant to the provisions set forth in 28 U.S.C. § 636(c).

III. PRINCIPLES OF REVIEW

Title 42, United States Code, Section 405(g) provides that the Commissioner's final determination following an administrative hearing not to award disability insurance benefits is subject to judicial review. 42 U.S.C. § 405(g). 42 U.S.C. § 405(g) provides the Court with the power to: "[E]nter . . . a judgment affirming, modifying, or reversing the decision of the Commissioner . . . with or without remanding the cause for a rehearing." 42 U.S.C. § 405(g). "The findings of the Commissioner . . . as to any fact, if supported by substantial evidence, shall be conclusive . . ." *Id*.

The Court must consider "whether the ALJ's decision is supported by substantial evidence on the record as a whole." *Vester v. Barnhart*, 416 F.3d 886, 889 (8th Cir. 2005) (citing *Harris v. Barnhart*, 356 F.3d 926, 928 (8th Cir. 2004)). Evidence is "substantial evidence" if a reasonable person would find it adequate to support the ALJ's determination. *Id*. (citing *Sultan v. Barnhart*, 368 F.3d 857, 862 (8th Cir. 2004)). Furthermore, "[s]ubstantial evidence is 'something less than the weight of the evidence, and the possibility of drawing two inconsistent conclusions does not prevent an administrative agency's findings from being supported by substantial evidence.'" *Baldwin v. Barnhart*, 349 F.3d 549, 555 (8th Cir. 2003) (quoting *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989), in turn quoting *Consolo v. Fed. Mar. Comm'n*, 282 U.S. 607, 620 (1966)).

In determining whether the ALJ's decision meets this standard, the Court considers "all of the evidence that was before the ALJ, but it [does] not re-weigh the evidence." *Vester*, 416 F.3d at 889 (citing *Guilliams v. Barnhart*, 393 F.3d 798, 801 (8th Cir. 2005)). The Court not only considers the evidence which supports the ALJ's decision, but also the evidence that detracts from his or her decision. *Guilliams*, 393 F.3d at 801. "[E]ven if inconsistent conclusions may be drawn from the evidence, the agency's decision will be upheld if it is supported by substantial evidence on the record as a whole." *Id*. (citing *Chamberlain v. Shalala*, 47 F.3d 1489, 1493 (8th Cir. 1995)).

IV. FACTS

A. Anderson's Education and Employment Background

Anderson was born in 1967. He completed the twelfth grade and completed certified nurse's assistant ("CNA") training at the College of Lake County in Grayslake, Illinois. Anderson did not, however, seek CNA certification by the state board. In 1990, Anderson performed CNA-type work at Lake Bluff Health Care Centre, Inc. and Amidei Home Health Care, Inc. In 1991, he built packaging machines at Prototype Equipment Corp. He was a cook at Hardee's in 1992. In 1993, Anderson worked as a maintenance worker for Six Flags Theme Parks, Inc. From 1993 to 1994, he worked at Accurate Transmissions, Inc. In 1994, Anderson also worked for Forty-One News, Incorporated as a bookstore attendant. From 1995 to 1999, he worked for Trzebry Brothers, Ltd. as a custom cabinet finisher. In 1999 and 2000, Anderson worked in the storeroom for Chemetco, Inc. From 2000 to 2001, he worked at Frontier Furnishings Company, Inc. as a custom cabinet finisher. He also worked for Jim Droste Carpentry, Inc. as a custom cabinet finisher from 2001 to 2003. Anderson has not worked since his alleged disability onset date of July 11, 2003.

B. Administrative Hearing Testimony

1. Anderson's Testimony

At the October 6, 2005 administrative hearing, Anderson testified that in July, 2003, doctors discovered a blood clot in his left leg. He testified that he continues to have swelling in his left leg and have Coumadin therapy to prevent another blood clot from forming in that

leg. He testified that standing, walking, or sitting for long periods causes his leg to swell. He further testified that he could stand for about forty-five minutes and sit for about an hour before having to change positions.

Anderson also testified that he suffers from chronic pain. He testified that he experiences the most pain in his wrists, shoulders, neck, knees, and ankles. He testified that his chronic pain is connected to his diagnosis of fibromyalgia. He testified that his pain is an eight or nine on a scale of ten. He testified that pain medication does not help alleviate his pain because the Coumadin therapy negates the effects of any pain medication he has tried in the past.[2]

Anderson also testified that he has dealt with depression for most of his life. He testified that he takes Effexor to treat his depression. Anderson also testified that he has anxiety attacks when he goes out in public and is around a lot of people. Lastly, Anderson testified that he suffers from carpal tunnel syndrome and rheumatoid arthritis.

2. Dianna Anderson's Testimony

Dianna Anderson ("Dianna") is Anderson's wife. They have been married since 2000. At the hearing, Anderson's attorney questioned Dianna regarding her husband's health and pain. Dianna testified that Anderson suffers pain in his legs which make walking and sitting for long periods of time difficult. She testified that he needs to change positions or change activities after twenty or thirty minutes. She further testified that Anderson has a low energy level. Dianna testified that Anderson is "frustrated and . . . [has] trouble remembering things. And I think he's concerned about it all of the time."[3] Anderson's attorney and Dianna had the following colloquy regarding the manner in which Anderson deals with his pain while he is at home during the day:

> Q: Okay. What kinds of things does [Anderson] do around the house when you're home that you've observed as far

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[2] Specifically, Anderson noted that Vicodin, Darvocet, and a Duragesic Patch did not alleviate his pain.

[3] *See* Administrative Record at 490.

as trying to get himself more comfortable with pain? What does he do?

A: Alternate sitting and standing frequently, elevating his leg fully, not just up on something in a seated position. He does have to lay down two or four hours to totally lay flat.

Q: To get the -- what's the purpose of that?

A: To totally alleviate the pain as far as the sitting and standing alternate. He does have to lay completely flat to get rid of the pain.

Q: Okay. And so, if you're home on the weekend, is that what he does a lot?

A: Uh-huh. He does take a nap every day two to four hours even on the weekends and during the week.

Q: Okay. And do you have a child at home?

A: We have a 10-year-old.

Q: Right. And does he care for that child at all? Does he do any child care?

A: He -- well, he's in school, our son --

Q: Right.

A: -- and then what [Anderson] usually does is take a nap between 10:00 [a.m.] and 2:00 [p.m.] That way, when [our son] gets home from the bus, [Anderson] can be there with him.

(Administrative Record at 491) Dianna also testified that Anderson goes grocery shopping once per week and does some of the laundry each week.

3. Vocational Expert's Testimony

Anderson's attorney provided vocational expert Carma Mitchell with a hypothetical for an individual with the following limitations:

> [The individual] continues to have the post phlebitic syndrome with swelling and pain and so forth to the degree that he [or she] would need to take frequent breaks during the day and [sit] no more than 30 minutes at a time without changing positions, stand no longer than 30 minutes at a time without changing positions, that the duration of the sitting and standing, during the day, would be limited to about four hours. And that he [or she] would need to take time off from any employment where he [or she] would have to lie down to relieve the pain. That he [or she] would frequently miss work more than three days . . . a month.

> That he [or she] would have problems with staying focused on the job to the degree that he [or she] would work at a slow pace up to a third of the time.

(Administrative Record at 497-98) Applying these limitations to Anderson, Anderson's attorney asked the vocational expert whether there were any jobs Anderson could perform. The vocational expert testified that Anderson could not return to his past work and would not be able to transfer any acquired skills to another job or perform any work on a full-time competitive basis.

The ALJ also provided the vocational expert with a hypothetical for an individual with the following limitations:

> [The individual would be limited] to work done where he [or she] would have the opportunity to alternate between sitting and standing in order to achieve maximum comfort. . . . [The individual] should comfortably be able to sit one-and-a-half hours before he [or she] needs to change positions. . . . [The individual] should be able to occasionally lift 20 pounds, frequently lift 10 pounds, sitting, standing, and walking, I would say he [or she] should be able to stand and walk with normal breaks in an eight-hour workday. [The individual] can't repetitively climb, stoop, and crouch, crawl, and kneel. [The individual has n]o environmental limitations, no communicative limitations, and basically no upper extremity limitations. . . . He [or she] doesn't have a severe mental impairment which would preclude him [or her] from working.

(Administrative Record at 503) The vocational expert testified that under such limitations, Anderson could perform his past job as a bookstore attendant. The ALJ also asked the vocational expert whether Anderson had acquired any skills which could be transferred to other jobs in the national economy. The vocational expert testified that Anderson's skills acquired as a nurse's assistant could transfer to jobs such as companion and blind aide (2,000 positions in Iowa and 233,000 positions in the nation). The vocational expert also testified that Anderson's skills from working as a storeroom clerk could transfer to the job of order filler (2,000 positions in Iowa and 200,000 positions in the nation). The ALJ also asked whether there were any unskilled jobs Anderson could perform. The vocational expert

testified that Anderson could work as a mail clerk (600 positions in Iowa and 40,000 positions in the nation) or an office machine operator (270 positions in Iowa and 24,000 positions in the nation). Lastly, the ALJ asked whether there were any sedentary positions Anderson could perform. The vocational expert testified that Anderson could work as a surveillance monitor (200 positions in Iowa and 33,000 positions in the nation) or an order clerk (200 positions in Iowa and 17,000 positions in the nation).

C. Anderson's Medical History

In a letter dated June 30, 2003, Dr. Frank I. Russo, M.D., discussed his examination of Anderson regarding Anderson's complaints of pain in his upper extremities. Dr. Russo made the following findings:

> Examination of the cervical spine reveals some mild tenderness in the cervical paraspinals and upper trapezii. Range of motion is near normal with slight pulling discomfort on the extremes of motion but no radicular symptoms. . . . Inspection of the upper extremities reveals no focal atrophy or asymmetry. Deep tendon reflexes are normal[,] active and symmetrical. Manual muscle testing reveals grossly normal strength. There is tenderness on palpation of the right dorsal forearm along the ulnar border probably corresponding with the extensor carpi ulnaris or extensor digitorum communis. [Anderson] has a negative Tinel's for the right median nerve at the wrist but mildly positive Tinel's for the left median nerve and both ulnar nerves at the elbow. . . . There is patchy alteration in pinprick sensation between the two upper extremities which does not correspond to a specific peripheral nerve or dermatome distribution.
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> Needle EMG was performed on the right upper extremity testing muscles representing myotomes C-5 -- T-1. All muscles tested revealed normal insertional activity. There was no increased muscle membrane irritability, that is, no positive ways or fibrillations were noted. Activated motor unit potentials were of normal amplitude and duration and recruitment was normal. . . . Motor conductions of the right median, ulnar, radial nerves and left median and ulnar nerves revealed normal evoked motor responses, normal distal latencies, and normal conduction velocities in all segments tested. Sensory studies of the right median, ulnar, and radial nerves and left median and ulnar

> nerves revealed normal evocaked sensory responses, distal latencies, and conduction velocities in those segments tested. There was no electrical evidence of focal neuropathy or more generalized neuropathy.

(Administrative Record at 212-13) Dr. Russo concluded that Anderson had normal EMG findings for the muscles that were tested. Dr. Russo also concluded that the nerves in Anderson's upper extremities had normal electrical findings. Dr. Russo did diagnose Anderson, however, with tendinitis of the right dorsal forearm.

On August 13, 2003, Anderson went to the emergency room at OSF Saint Francis Hospital in Peoria, Illinois with complaints of pain and swelling in his left leg. A doppler sonogram study showed deep vein thrombosis ("DVT"). Anderson was hospitalized and given a Heparin drip and Lovenox. Anderson also underwent Coumadin therapy. Anderson was discharged from the hospital on August 18, 2003 with instructions to continue the Coumadin therapy and Lovenox medication.

On September 26, 2003, after a doppler sonogram study suggested a "proximal extension of previous deep vein thrombosis into the popliteal,"[4] Anderson was admitted to the hospital again. Subsequent examination of Anderson's left leg, on September 17, 2003, revealed that DVT had not reoccurred. Anderson was instructed to continue Coumadin therapy as treatment.

In 2003, Dr. Sachdev P. Thomas, M.D., one of Anderson's treating doctors, provided Disability Determination Services ("DDS") with four reports regarding Anderson's physical health.[5] The first undated report provided that Anderson's activities should be limited because he was at a high risk for bleeding if injured. Dr. Thomas also noted that Anderson would need intermittent rest. In the second undated report, Dr. Thomas provided several limitations for Anderson. Specifically, Dr. Thomas opined that Anderson (1) could only stand or walk for short periods of time; (2) should lift no more than five pounds;

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[4] *See* Administrative Record at 255.

[5] Two of the reports are undated and the other two reports are dated October 6, 2003 and December 3, 2003.

(3) could sit or stand for twenty to thirty minutes at a time; and (4) would need to alternate positions at least every twenty to thirty minutes. Dr. Thomas further opined that Anderson could not even perform sedentary work at that time. Dr. Thomas summarized his findings as follows:

> [Anderson] has impairments with activities due to symptoms of pain in [his] leg and history of DVT. [Anderson is at] very high risk for bleeding on Coumadin. . . . He also has pain from fibromyalgia. [It is] very important that [Anderson] remains on this high dose [of] Coumadin with close monitoring related to bleeding and [the possibility of] DVT.

(Administrative Record at 324) In a report dated October 6, 2003, Dr. Thomas reiterated his concern that Anderson be limited in his activities due to the high risk of bleeding while undergoing Coumadin therapy. Dr. Thomas provided a report dated December 3, 2003 which was nearly identical to the other reports and noted for a second time that Anderson's limitations made even sedentary work impossible. Additionally, in a letter dated December 23, 2003, Dr. Thomas noted that due to Anderson's use of Coumadin, the medicine used to control his rheumatologic disorders was no longer effective and Anderson developed a "significant disability in that he is not able to sit, stand, or turn around for even a brief period of time."[6] Thus, Dr. Thomas concluded that Anderson was totally disabled.[7]

In a letter dated November 14, 2003, Dr. Juan Chediak, a hematologist, reviewed his findings after a consultative examination of Anderson for Dr. Thomas and provided pertinent information regarding Anderson's medical history. With regard to Anderson's medical history, Dr. Chediak noted:

> In 1996, [Anderson] was evaluated by Dr. Katz because of the possibility of fibromyalgia. The antinuclear antibodies at that time were positive, and [Anderson] was diagnosed having chronic fatigue syndrome. . . . In addition to the fibromyalgia and chronic fatigue syndrome[, Anderson] was diagnosed having Raynaud syndrome with changes in the color of the tips of his

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[6] *See* Administrative Record at 336.

[7] *Id.* ("I believe [Anderson's] application for total disability is appropriate.").

> fingers. . . . Finally in 1990, [Anderson] was diagnosed having Klinefelter syndrome due to a lack of offspring. . . . In July 2003, he was diagnosed having carpal tunnel syndrome as well. . . . [Anderson also] had some learning disabilities as a child. He had delayed speech and problems with short term memory loss. He had no special education while in High School and he was admitted at age 16 for depression.

(Administrative Record at 328-29) Upon examining Anderson, Dr. Chediak found "the factor V Leiden was negative, the homocysteine level was normal, the lupus anticoagulant was negative, the cardiolipin antibodies were negative, the rheumatoid factor was negative, and the prothrombin gene mutation . . . was completely normal."[8] Dr. Chediak suggested that Anderson be treated with Heparin, Lovenox, and Coumadin.

On January 19, 2004, Anderson was examined by Dr. Robert S. Katz, M.D., a rheumatologist. Dr. Katz took radiographs of Anderson's hands, shoulders, feet, and knees. Dr. Katz found all of the radiographs to be normal. Dr. Katz also took radiographs of Anderson's cervical spine. Dr. Katz found these radiographs to be normal as well.

On September 24, 2004, Anderson saw Dr. Thomas for a routine DVT follow-up visit. Dr. Thomas noted that Anderson's Coumadin therapy had been "therapeutic." Dr. Thomas also noted that Anderson's "recent Doppler study, which was negative, did not show any evidence of recurrent DVT."[9] Dr. Thomas further noted that the swelling and Anderson's leg was almost completely resolved. Dr. Thomas concluded that Anderson's DVT was completely resolved. Dr. Thomas, however, had Anderson continue with the Coumadin therapy.

On July 26, 2005, Anderson visited the Rheumatology Department at the University of Iowa Hospitals and Clinics for a second opinion regarding fibromyalgia and possible

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[8] *See* Administrative Record at 329.

[9] *See* Administrative Record at 385.

lupus. Anderson was examined by Dr. Janelle Regier, M.D.[10] Dr. Regier noted that Anderson rated his pain as a 7 out of 10 on a scale of 1 to 10. He reported pain in his fingers, wrists, elbows, shoulders, ankles, and toes. Anderson informed Dr. Regier that he tried Vicodin, Darvocet, Flexeril, Percodan, and a Duragesic patch to control his pain in the past. Dr. Regier noted that at the time of the examination, Anderson was not taking any medication to control his pain. Dr. Regier also noted that Anderson was diagnosed with obstructive sleep apnea syndrome. Dr. Regier further noted that it was recommended that Anderson use a CPAP machine to control the sleep apnea. Anderson informed Dr. Regier, however, that he could not tolerate the CPAP machine and did not use any treatment for the sleep apnea. Dr. Regier also noted that Anderson was diagnosed with Klinefelter's syndrome in 1990. Lastly, Dr. Regier noted that Anderson previously had problems with depression, but he stated that his depression was "fairly well controlled at this point."

After performing a musculoskeletal exam, Dr. Regier made the following findings:

> [Anderson] has normal range of motion in the neck which is nonpainful. Examination of his hands is negative for any swelling, erythema, or tenderness in the MCPs, PIPs, or DIPs. Grip strength is 5/5. Examination of the wrists is normal. There is no sign of erythema, swelling or tenderness. Extension and flexion at the elbow are normal. . . . He has full range of motion in the shoulders. Lower extremities: Examination of his feet is negative for tenderness, swelling or erythema of the joints of his feet or ankles. He has normal range of motion in his ankles and knees. . . . Fibromyalgia tender points: He does have mild tenderness at the left second costochondral junction. He also has mild tenderness at the medial fat pad of the right knee. Other tender points were negative.

(Administrative Record at 438) Dr. Regier diagnosed Anderson with Klinefelter's syndrome, hypotestosteronemia secondary to Klinefelter's syndrome, untreated obstructive sleep apnea syndrome, depression likely related to untreated obstructive sleep apnea

[10] It appears from the record that Dr. Rebecca Tuetken, M.D., was also involved in interviewing and examining Anderson and reviewed Dr. Regier's work on Anderson's visit on July 26, 2005.

syndrome, low testosterone related to his Klinefelter's syndrome, hyperhomocysteinemia currently on treatment with Foltex, and DVT, secondary to hyperhomocysteinemia of the left lower extremity. Dr. Regier also noted that:

> It is our impression today that [Anderson] does not have symptoms consistent with a diagnosis of fibromyalgia at this point in time. It is possible that the stress due to the death of his father and brother nine years ago was reflected in [Anderson's] musculoskeletal complaints at that time. Also [Anderson] has untreated obstructive sleep apnea syndrome which is currently not being treated, which will also add to his fatigue.

(Administrative Record at 439) Dr. Regier also found that Anderson did not meet the criteria for a diagnosis of lupus. Dr. Regier recommended treating Anderson with Hydroxycholoquine, testosterone replacement, a CPAP for sleep apnea, and therapy for depression.

On July 29, 2005, Anderson saw Dr. Thomas W. Hansen, M.D., for a psychiatric evaluation. In discussing Anderson's psychiatric history, Dr. Hansen noted that he was depressed at the age of seven and saw a therapist for three years. Dr. Hansen further noted that at age fifteen, Anderson was hospitalized for a month due to a combination of drug and alcohol abuse and depression. Anderson also told Dr. Hansen that growing up he could not articulate words clearly. Anderson informed Dr. Hansen that until he was eight or nine, the only person who could understand him was his mother. Dr. Hansen also noted that in 2003, Anderson began suffering from anxiety and having panic attacks. Dr. Hansen also discussed the medication Anderson used, beginning in 2003, to treat his depression and anxiety:

> [Anderson] was on Paxil for two years. That worked pretty well. While he was having the panic attacks, he developed a lot of agoraphobia. He could not go out anywhere where there [were] a lot of people. . . . Later, [he was taken] off the Paxil and put . . . on . . . Wellbutrin. He was on that for about six months. . . . [Next, h]e was started on Effexor, got up to 150 mg, and it worked quite well for his mood. If he does not take it he says he starts having thoughts about what life is all about and what death is all about. He does not get exactly suicidal, but his thinking gets to be somewhat morbid. At this time, he

> is on 150 mg of Effexor. For insomnia, he has trazadone up to 300 mg.

(Administrative Record at 447) Dr. Hansen diagnosed Anderson with unipolar depression with anxiety attacks. Dr. Hansen noted that Anderson was "content with the Effexor at this time." Dr. Hansen made no further appointments for Anderson, but stated he would "be happy to see him in the future for treatment."

V. CONCLUSIONS OF LAW

A. ALJ's Disability Determination

The ALJ determined that Anderson is not disabled. In making this determination, the ALJ was required to complete the five-step sequential test provided in the social security regulations. *See* 20 C.F.R. § 404.1520(a)-(f); *Bowen v. Yuckert*, 482 U.S. 137, 140 (1987); *Page v. Astrue*, 484 F.3d 1040, 1042 (8th Cir. 2007); *Anderson v. Barnhart*, 344 F.3d 809, 812 (8th Cir. 2003). The five steps an ALJ must consider are:

> (1) whether the claimant is gainfully employed, (2) whether the claimant has a severe impairment, (3) whether the impairment meets the criteria of any Social Security Income listings, (4) whether the impairment prevents the claimant from performing past relevant work, and (5) whether the impairment necessarily prevents the claimant from doing any other work.

Goff v. Barnhart, 421 F.3d 785, 790 (8th Cir. 2005) (citing *Eichelberger v. Barnhart*, 390 F.3d 584, 590 (8th Cir. 2004)); *see also* 20 C.F.R. § 404.1520(a)-(f). "If a claimant fails to meet the criteria at any step in the evaluation of disability, the process ends and the claimant is determined to be not disabled." *Eichelberger*, 390 F.3d at 590-91 (citing *Ramirez v. Barnhart*, 292 F.3d 576, 580 (8th Cir. 2002)).

"To establish a disability claim, the claimant bears the initial burden of proof to show that he [or she] is unable to perform his [or her] past relevant work." *Frankl v. Shalala*, 47 F.3d 935, 937 (8th Cir. 1995) (citing *Reed v. Sullivan*, 988 F.2d 812, 815 (8th Cir. 1993)). If the claimant meets this burden, the burden of proof then shifts to the Commissioner to demonstrate that the claimant retains the residual functional capacity to perform a significant number of other jobs in the national economy that are consistent with claimant's impairments

and vocational factors such as age, education, and work experience. *Id*. The RFC is the most an individual can do despite the combined effect of all of his or her credible limitations. 20 C.F.R. § 416.945. "'It is the ALJ's responsibility to determine a claimant's RFC based on all relevant evidence, including medical records, observations of treating physicians and others, and claimant's own descriptions of his [or her] limitations.'" *Tellez v. Barnhart*, 403 F.3d 953, 957 (8th Cir. 2005) (quoting *Pearsall v. Massanari*, 274 F.3d 1211, 1217 (8th Cir. 2001)).

The ALJ applied the first step of the analysis and determined that Anderson had not engaged in substantial gainful activity since his alleged onset date, July 11, 2003. At the second step, the ALJ concluded, from the medical evidence, that Anderson had the following impairments "deep vein thrombosis, chronic fatigue syndrome, and obesity." At the third step, the ALJ found that Anderson did not have "an impairment or combination of impairments which specifically meets or equals the criteria of any impairment listed in [20 C.F.R. § 404,] Appendix 1, Subpart P, Regulations No. 4 (the Listing of Impairments)." At the fourth step, the ALJ determined Anderson's RFC as follows:

> [Anderson can] occasionally lift 20 pounds and frequently lift ten pounds, sit a total of six hours in an eight hour day and stand/walk a total of six hours in an eight hour day with normal breaks. [Anderson] would need to alternate sitting and standing. He could occasionally climb, balance, stoop, crouch, kneel and crawl.

Using this RFC, the ALJ determined that Anderson could perform his past relevant work as a bookstore attendant and had transferable skills to perform other jobs in the national economy such as companion, blind aide, order filler, mail clerk, office machine attendant, surveillance system monitor, or order clerk. Therefore, the ALJ concluded that since Anderson was capable of performing his past relevant work and other work in the national economy, he was "not disabled."

B. Anderson's Residual Functional Capacity

Anderson contends that the ALJ erred in four respects. First, Anderson argues that the ALJ failed to consider all of the medical evidence in determining the severity of his

impairments. Second, Anderson argues that the ALJ failed to follow the requisite special technique for evaluating his mental impairments. Third, Anderson argues that the ALJ failed to fully and fairly develop the record for his multiple medical conditions by not seeking expert testimony from his treating doctors or from a consultative source. Lastly, Anderson argues that the ALJ failed to properly consider his subjective allegations of disability. Anderson requests that the Court reverse the Commissioner's decision and remand it with directions to award benefits. Alternatively, Anderson requests this matter be remanded for further proceedings. The Commissioner argues that there is substantial evidence in the record as a whole which supports the ALJ's decision; and therefore, the decision should be affirmed.

1. Consideration of the Medical Evidence

Anderson argues that the ALJ failed to consider several of Anderson's medical conditions when determining whether he had any disabling impairments. Anderson points out that the ALJ did not consider or discuss the possibility of physical limitations due to his diagnosis of post-phlebitic syndrome[11] by Dr. David W. Zenk, M.D., on March 7, 2005 and Dr. Regier on July 26, 2005.[12] Anderson also asserts that the ALJ failed to properly discuss his allegations of fatigue. Specifically, Anderson argues that the ALJ failed to consider the effects Klinefelter's syndrome and untreated obstructive sleep apnea syndrome have on his allegation of fatigue. Lastly, Anderson points out that the ALJ determined his obesity to be a severe impairment. As such, Anderson contends that the ALJ was required to consider his obesity in combination with his other impairments and make a determination regarding whether the combined effect of his obesity and other impairments creates a functional limitation.

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[11] Post-phlebitic syndrome pertains to complications that may follow DVT. Such complications include persistent edema, pain, purpura, eczematoid dermatitis, pruritus, ulceration, and cellulitis. These complications are the result of the impaired return of blood through the veins of the lower leg to the heart. *See* MedicineNet.com, *available at* www.medterms.com/script/main/art.asp?articlekey=38491.

[12] *See* Administrative Record at 416 and 437.

An ALJ has the responsibility of assessing a claimant's RFC, and his or her assessment must be based on all of the relevant evidence. *Guilliams*, 393 F.3d at 803; *see also Roberts v. Apfel*, 222 F.3d 466, 469 (8th Cir. 2000) (same). Relevant evidence for determining a claimant's RFC includes "'medical records, observations of treating physicians and others, and an individual's own description of his [or her] limitations.'" *Lacroix v. Barnhart*, 465 F.3d 881, 887 (8th Cir. 2006) (quoting *Strongson v. Barnhart*, 361 F.3d 1066, 1070 (8th Cir. 2004)). However, "RFC is a medical question, and an ALJ's finding must be supported by some medical evidence." *Guilliams*, 393 F.3d at 803 (citing *Masterson v. Barnhart*, 363 F.3d 731, 738 (8th Cir. 2004)). Furthermore, the ALJ must consider the "combined effect of all impairments without regard to whether any such impairment, if considered separately would be of sufficient medical severity to be disabling." *Cunningham v. Apfel*, 222 F.3d 496, 501 (8th Cir. 2000) (citing 20 C.F.R. § 404.1523 and *Delrosa v. Sullivan*, 922 F.2d 480, 484 (8th Cir. 1991)). Moreover, the ALJ has a duty to develop the record fully and fairly. *Cox v. Astrue*, 495 F.3d 614, 618 (8th Cir. 2007); *Sneed v. Barnhart*, 360 F.3d 834, 838 (8th Cir. 2004); *Wilcutts v. Apfel*, 143 F.3d 1134, 1137 (8th Cir. 1998). Because an administrative hearing is a non-adversarial proceeding, the ALJ must develop the record fully and fairly in order that "'deserving claimants who apply for benefits receive justice.'" *Wilcutts*, 143 F.3d at 1138 (quoting *Battles v. Shalala*, 36 F.3d 43, 44 (8th Cir. 1994)).

On March 7, 2005, Dr. Zenk diagnosed Anderson with "probable" post-phlebitic syndrome. Additionally, in treatment notes from July, 2005, Dr. Regier included post-phlebitic syndrome in her discussion of Anderson's medical history. The ALJ's decision does not mention post-phlebitic syndrome. The Commissioner, however, correctly points out that neither Dr. Zenk, Dr. Regier, nor the medical evidence in the record contains a definitive diagnosis of post-phlebitic syndrome for Anderson. The Commissioner further points out that Anderson testified at the hearing, that his treatment for post-phlebitic syndrome is "not much of anything. They made me wear support hose, hopefully, that . . .

[will keep the swelling] . . . restricted."[13] The Court finds that the ALJ's decision to disregard Anderson's "probable" diagnosis of post-phlebitic syndrome does not constitute a failure to fully and fairly develop the record because there is no indication in the record that a "probable" diagnosis of post-phlebitic syndrome would create a disabling limitation affecting Anderson's RFC.

Next, the ALJ found Anderson's diagnosis of Klinefelter's syndrome to be a "non severe limitation." In her decision, the ALJ stated "Klinefelter's syndrome, which [Anderson] was born with, does not impose any disabling limitations."[14] The ALJ also determined that Anderson was impaired by chronic fatigue syndrome. Dr. Regier, in the July, 2005 treatment notes, indicated that Klinefelter's syndrome effected Anderson's "fatigue and muscoskeletal complaints."[15] Dr. Regier also determined that Anderson's untreated obstructive sleep apnea syndrome also effected his complaints of fatigue. The ALJ's decision does not discuss Dr. Regier's findings that Klinefelter's syndrome and untreated obstructive sleep apnea effect his complaints of fatigue.

With regard to the sleep apnea, the ALJ, in her decision, states "[Anderson has a] past history of sleep difficulties and provisional diagnosis of sleep apnea was noted. [Anderson] advised he had been unable to tolerate the CPAP unit and was currently receiving no treatment."[16] The Commissioner seizes on this language in the ALJ's decision and argues that the ALJ properly considered Anderson's sleep apnea and properly dismissed it as an impairment because Anderson failed to seek regular treatment for the condition or follow the recommended treatment. "'Failure to follow a prescribed course of remedial treatment without good reason is grounds for denying an application for benefits.'" *Brown v. Barnhart*, 390 F.3d 535, 540 (8th Cir. 2004) (quoting *Roth v. Shalala*, 45 F.3d 279, 282

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[13] *See* Administrative Record at 475.

[14] *See* Administrative Record at 19.

[15] *See* Administrative Record at 439.

[16] *See* Administrative Record at 21.

(8th Cir. 1995)); *see also* 20 C.F.R. § 416.930(b) (this section provides "[i]f you do not follow the prescribed treatment without good reason, we will not find you disabled. . . ."). The ALJ points out that Anderson "advised he had been unable to tolerate the CPAP unit" used to treat sleep apnea. The ALJ, however, makes no determination regarding whether Anderson's inability to tolerate the CPAP is a good or bad reason for not following that treatment. Furthermore, because the ALJ did not discuss Dr. Regier's findings that Klinefelter's syndrome and obstructive sleep apnea effected his complaints of fatigue, the Court determines that the ALJ failed to fully and fairly develop the record regarding Anderson's fatigue and the effect Klinefelter's syndrome and obstructive sleep apnea have on that fatigue. *See Cox*, 495 F.3d at 618 (The ALJ has a duty to develop the record fully and fairly.); *see also Cunningham*, 222 F.3d at 501 (The ALJ must consider the "combined effect of all impairments without regard to whether any such impairment, if considered separately would be of sufficient medical severity to be disabling."). Accordingly, the Court finds that remand is appropriate for the ALJ to consider and more fully develop the record with regard to the effects Klinefelter's syndrome and obstructive sleep apnea syndrome have on Anderson's complaints of fatigue. On remand, the ALJ should also address Anderson's reasons for not treating his obstructive sleep apnea.

Lastly, the ALJ determined that Anderson was impaired by his obesity. The ALJ correctly set forth the law regarding a finding of obesity as an impairment. The ALJ's decision provided:

> The undersigned has given consideration to Social Security Ruling 02-1p which instructs adjudicators to consider the effects of obesity not only under the listings, but also when assessing a claim at other steps of the sequential evaluation process, including when assessing an individual's residual functional capacity. When obesity is identified as a medically determinable impairment, consideration will be given to any functional limitations resulting from the obesity in the residual functional

> capacity assessment in addition to any limitations resulting from any other physical or mental impairments identified.[17]

(Administrative Record at 21) The ALJ, however, fails to apply the law to her finding that Anderson is impaired by his obesity because she does not discuss his obesity in conjunction with his other impairments or the effect his obesity has on his allegation of disability. The Court finds that remand is appropriate for the ALJ to consider the effects of Anderson's obesity on the determination of whether he disabled. The ALJ should also discuss the effect of Anderson's obesity in conjunction with his other impairments, including the medical evidence regarding Klinefelter's syndrome and obstructive sleep apnea syndrome.

2. The Requisite Special Technique for Mental Impairments

Anderson argues that the ALJ failed to properly evaluate his mental impairment because the ALJ did not apply the special technique for evaluating mental impairments which is set forth in 20 C.F.R. § 404.1520a. Anderson further argues that the ALJ was not only required to apply the special technique, but was also required to discuss and incorporate the pertinent findings and conclusions of applying the technique in her written decision. *See* 20 C.F.R. § 404.1520a(e)(2); *see also Nicola v. Astrue*, 480 F.3d 885, 887 (8th Cir. 2007) ("The psychiatric review technique must also be conducted and documented at the ALJ [level and] . . . it is permissible for the analysis to be included within the written decision such that the use of a written form is not required.").

The ALJ found that Anderson's depression was a "non severe" impairment which did not impose any functional limitations. Specifically, the ALJ determined that "Anderson's depression has been treated and controlled by the use of medications during the relevant

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[17] *See* Social Security Ruling 02-1p. The ruling provides that the Social Security Administration considers "obesity to be a medically determinable impairment and remind[s] adjudicators to consider its effects when evaluating disability. The provisions also remind adjudicators that the combined effects of obesity with other impairments can be greater than the effects of each of the impairments considered separately."

period [of alleged disability]."[18] The record supports the ALJ's conclusion that Anderson's depression has been treated and controlled by the use of medication. Specifically, the record provides treatment notes from Dr. Regier discussing Anderson's medical history. In her notes, Dr. Regier pointed out that Anderson had problems with depression, and noted that he takes medication and "[h]e thinks his depression is fairly well controlled at this point."[19] The record further provides that on July 29, 2005, Anderson had a one-time visit with Dr. Hansen for a psychiatric evaluation. Dr. Hansen diagnosed Anderson with unipolar depression with anxiety attacks. Dr. Hansen noted that Anderson treated his depression with medication and found that Anderson was "content with the Effexor at this time."[20] Additionally, at the administrative hearing, Anderson had the following colloquy with the ALJ:

> Q: . . . So basically you saw this Dr. Hanson [sic] once?
> A: Yes.
> Q: Okay. And then you wanted treatment?
> A: He said that if I feel I need to come back and see him that I should.
> Q: Okay. But he didn't put you onto treatment?
> A: No.
> Q: So can we assume that your depression and anxiety is not that severe then?
> A: I'm on the Effexor XR and it seems to work good if I take it.

(Administrative Record at 502)

"'If an impairment can be controlled by treatment or medication, it cannot be considered disabling.'" *Brown*, 390 F.3d at 540 (quoting *Roth*, 45 F.3d at 282, in turn quoting *Stout v. Shalala*, 988 F.2d 853, 855 (8th Cir. 1993)); *see also Estes v. Barnhart*, 275 F.3d 722, 725 (8th Cir. 2002) (citation omitted) ("An impairment which can be

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[18] *See* Administrative Record at 19.

[19] *See* Administrative Record at 437.

[20] *See* Administrative Record at 448.

controlled by treatment or medication is not considered disabling."). The Court finds that there is substantial evidence in the record to support the ALJ's conclusion that Anderson's depression was controlled by medication; and therefore, not disabling. Accordingly, the Court finds that it was unnecessary in this case, for the ALJ to apply the special technique for evaluating mental impairments which is set forth in 20 C.F.R. § 404.1520a.

3. Additional Medical Opinion Evidence

Anderson argues that the ALJ did not fully and fairly develop the record in this case and "[t]his matter should be remanded to obtain work-related limited from a treating or a consultative physician."[21] Anderson further argues that the record is unclear as to the work limitations he may have due to the various test results and diagnoses provided by his treating doctors. Therefore, Anderson maintains that expert medical testimony from his treating doctors or a consultative physician regarding potential work-related limitations is necessary for a fully and fairly developed record.

An ALJ is not required to "seek additional clarifying statements from a treating physician unless a crucial issue is undeveloped." *Stormo v. Barnhart*, 377 F.3d 801, 806 (8th Cir. 2004) (citation omitted). Furthermore, an ALJ is only required to order medical examinations and tests when the medical records presented to him or her constitute insufficient medical evidence to determine whether the claimant is disabled. *Barrett v. Shalala*, 38 F.3d 1019, 1023 (8th Cir. 1994) (citation omitted); *see also* 20 C.F.R. § 404.1519a(a)(1) ("The decision to purchase a consultative examination . . . will be made after we have given full consideration to whether the additional information needed is readily available from the records of your medical sources."). Additionally, 20 C.F.R. § 404.1519a(b) provides that "[a] consultative examination may be purchased when the evidence as a whole, both medical and nonmedical, is not sufficient to support a decision on . . . [the] claim." *Id*.

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[21] *See* Anderson's Brief at 17. The quoted material from Anderson's Brief is unclear, but the Court assumes that Anderson intended to state "[t]his matter should be remanded to obtain work related *limitations* from a treating or a consultative physician."

In section ***V.B.1*** of this decision, the Court remanded this matter to the ALJ for further consideration and development of the record with regard to the effects Klinefelter's syndrome, obstructive sleep apnea syndrome, and obesity have on Anderson's complaints of fatigue and other impairments. The Court remanded this case to the ALJ because the ALJ failed to properly consider or address the medical evidence contained in the record. Having reviewed the record, the Court finds that the medical evidence contained in this record is not insufficient for the ALJ to make her determinations when reconsidering and addressing the evidence on remand. Accordingly, the Court finds that the ALJ is not required to solicit expert medical testimony from Anderson's treating physicians or a consultative physician or order a consultative examination. *See Barrett*, 38 F.3d at 1023; 20 C.F.R. § 404.1519a(b). If in developing the record on remand, however, the ALJ determines that a consultative examination or further information from Anderson's treating doctors is necessary pursuant to 20 C.F.R. § 404.1519a, then the ALJ may order such an examination.

4. Credibility Determinations

Anderson argues that the ALJ improperly discredited his testimony regarding his subjective allegations of pain, functional limitations, and total disability and the similar testimony of his wife, Dianna. Anderson maintains that the ALJ misapplied the *Polaski* factors for determining the credibility of his testimony and Dianna's testimony. Specifically, Anderson argues that the ALJ failed to identify any inconsistencies between his testimony and Dianna's testimony and the record as a whole as required for making a credibility determination.

When evaluating the credibility of a claimant's subjective complaints, the ALJ may not disregard them "solely because the objective medical evidence does not fully support them." *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir. 1984). However, the absence of objective medical evidence to support a claimant's subjective complaints is a relevant factor for an ALJ to consider. *Gowell v. Apfel*, 242 F.3d 793, 796 (8th Cir. 2001) (citation omitted). "The [ALJ] must give full consideration to all the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third

parties and treating and examining physicians relating to such matters as: (1) the claimant's daily activities; (2) the duration, frequency, and intensity of the pain; (3) precipitating and aggravating factors; (4) dosage, effectiveness and side effects of medication; [and] (5) functional restrictions." *Polaski*, 739 F.2d at 1322. Subjective complaints may be discounted if inconsistencies exist in the evidence as a whole. *Pelkey v. Barnhart*, 433 F.3d 575, 578 (8th Cir. 2006) (citing *Polaski*, 739 F.2d at 1322). However, the ALJ must give reasons for discrediting the claimant. *Id.* (citing *Strongson v. Barnhart*, 361 F.3d 1066, 1072 (8th Cir. 2004)). Where an ALJ seriously considers, but for good reason explicitly discredits a claimant's subjective complaints, the Court will not disturb the ALJ's credibility determination. *Johnson v. Apfel*, 240 F.3d 1145, 1148 (8th Cir. 2001) (citing *Pena v. Chater*, 76 F.3d 906, 908 (8th Cir. 1996)); *see also Guilliams*, 393 F.3d at 801 (explaining that deference to an ALJ's credibility determination is warranted if the determination is supported by good reasons and substantial evidence). "'The credibility of a claimant's subjective testimony is primarily for the ALJ to decide, not the courts.'" *Wagner v. Astrue*, 499 F.3d 842, 851 (8th Cir. 2007) (quoting *Pearsall*, 274 F.3d at 1218). Additionally, assessment of the credibility of witness testimony lies within the province of the ALJ. *Siemers v. Shalala*, 47 F.3d 299, 302 (8th Cir. 1995). Deference is given to an ALJ's witness credibility determination, if his or her determination is supported by good reasons and substantial evidence. *Vester*, 416 F.3d at 889 (citation omitted).

In determining that Anderson's subjective allegations of pain, functional limitations, and total disability were not credible, the ALJ found:

> [Anderson] has alleged significant limitations that are not supported by the medical evidence. Although no one doubts he has experienced some pain and limitations, the record does not support the degree alleged. . . . [Anderson's] credibility is eroded.

(Administrative Record at 23) In determining that Dianna's testimony was not credible, the ALJ concluded:

> The testimony of [Dianna] does not establish that [Anderson] is disabled. Since she is not medically trained to make exacting

> observations as to dates, frequencies, types and degrees of medical signs and symptoms, or of the frequency or intensity of unusual moods or mannerisms, the accuracy of the testimony is questionable. Moreover, by virtue of the relationship as [Anderson's wife], the witness cannot be considered a disinterested third party witness whose testimony would not tend to be colored by affection for [Anderson] and a natural tendency to agree with the symptoms and limitations [Anderson] alleges. Most importantly, significant weight cannot be given to the witness's testimony because it, like [Anderson's], is simply not consistent with the preponderance of the opinions and observations by medical doctors in this case.

(Administrative Record at 23)

Similar to the issue of obesity discussed in section ***V.B.1*** of this decision, the ALJ properly set forth the law for making credibility determinations, but failed to apply the law in determining the credibility of Anderson and Dianna's testimony. Under *Polaski*, an ALJ may not disregard Anderson's allegations of pain, functional limitations, and total disability "solely because the objective medical evidence does not fully support them." *Polaski*, 739 F.2d at 1322. The ALJ's decision provides no reasons for discounting Anderson's testimony other than his allegations are not supported by the medical evidence. Additionally, there is nothing in the ALJ's decision which suggests she considered the *Polaski* factors. *See Id*. (The ALJ should consider: (1) the claimant's daily activities; (2) the duration, frequency, and intensity of the pain; (3) precipitating and aggravating factors; (4) dosage, effectiveness and side effects of medication; and (5) functional restrictions); *see also Pelkey*, 433 F.3d at 578 (the ALJ must give reasons for discrediting a claimant). Because the ALJ's decision lacks any discussion of an application of the *Polaski* factors or the reasons for discrediting Anderson, except that his allegations are not supported by the medical evidence, the Court finds that remand is appropriate for the ALJ to apply the law set forth in *Polaski* and further develop the record with regard to the credibility of Anderson's subjective allegations of pain, functional limitations, and total disability. Furthermore, on remand, the ALJ shall apply the *Polaski* factors and provide well developed and good reasons for finding Anderson credible or not credible. Additionally, the Court finds that on remand, the ALJ should also

reconsider the testimony of Anderson's wife, Dianna, in light of the ALJ's findings regarding Anderson's testimony.

C. Reversal or Remand

The scope of review of the Commissioner's final decision is set forth in 42 U.S.C. § 405(g) which provides in pertinent part:

> The court shall have the power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with our without remanding the cause for a rehearing.

42 U.S.C. § 405(g). The Eighth Circuit Court of Appeals has stated that:

> Where the total record is overwhelmingly in support of a finding of disability and the claimant has demonstrated his [or her] disability by medical evidence on the record as a whole, we find no need to remand.

Gavin v. Heckler, 811 F.2d 1195, 1201 (8th Cir. 1987); *see also Beeler v. Brown*, 833 F.2d 124, 127 (8th Cir. 1987) (finding reversal of denial of benefits was proper where "the total record overwhelmingly supports a finding of disability"); *Stephens v. Sec'y of Health, Educ., & Welfare*, 603 F.2d 36, 42 (8th Cir. 1979) (explaining that reversal of denial of benefits is justified where no substantial evidence exists to support a finding that the claimant is not disabled). In the present case, the Court concludes that the medical records as a whole do not "overwhelmingly support a finding of disability." *Beeler*, 833 F.2d at 127. Instead, the ALJ simply failed to fully and fairly develop the record with regard to Anderson's complaints of fatigue, the effects Klinefelter's syndrome, obstructive sleep apnea syndrome, and obesity have on Anderson's complaints of fatigue, and the credibility determinations for Anderson and his wife, Dianna. Accordingly, the Court finds that remand is appropriate.

VI. CONCLUSION

The Court concludes that this matter should be remanded to the Commissioner for further proceedings. On remand, the ALJ should develop the record fully and fairly, and address Anderson's complaints of fatigue, the effects Klinefelter's syndrome, obstructive sleep apnea syndrome, and obesity have on Anderson's complaints of fatigue. The ALJ

should also fully and fairly develop the record with regard to the credibility determinations for Anderson and his wife, Dianna.

VII. ORDER

For the foregoing reasons, it is hereby **ORDERED**:

This matter is **REVERSED** and **REMANDED** to the Commissioner of Social Security pursuant to sentence four of 42 U.S.C. § 405(g), for further proceedings as discussed herein.

DATED this 26th day of December, 2007.

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JON STUART SCOLES
United States Magistrate Judge
NORTHERN DISTRICT OF IOWA